Baystate Health

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March 3, 2010

David Morales
Commissioner
Executive Office of Health and Human Services
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Subject: Testimony for Public Hearing on Health Care Provider and Payer Costs and Trends

Dear Mr. Morales:

In response to your February 12, 2010 letter, we have prepared the following written testimony. The deadline for providing a response to your letter was very short and some of the requested information was not readily available in the format requested. Accordingly, the testimony submitted below has been prepared based on reasonable inquiry and is true and correct to the best of our knowledge, information and reasonable belief.

Division of Health Care Finance & Policy Questions and Baystate Medical Center (BMC) Testimony

1) After reviewing the preliminary reports located at www.mass.gov/dhcfp/costtrends please provide commentary on any data, or finding that differs from your organization's experience and the potential reasons therefore.

   BMC's 3.1% annual growth in inpatient commercial (see page 13 for what is included in commercial) revenue is significantly less than the 8.5% reflected in the DHCFP preliminary reports for all teaching hospitals in Massachusetts. BMC's 4.7% annual growth in outpatient commercial revenue is significantly less than the 12.1% reflected in DHCFP report for all outpatient facilities in Massachusetts.

   BMC's growth in inpatient revenue between FY2006 and FY2008 is primarily related to increases in the rates we received per service. Our growth also reflects some increase in volume and service intensity. The increase in rates is in line with our cost increases including wages, benefits, and other expenses during this period.

BMC's growth in outpatient revenue between FY2006 and FY2008 is related to a combination of increases in volume (1.1%); increase in the rates we received per service (1.9%) and increases in service intensity (1.7%). The increase in rates is in line with our cost increases, including wages, benefits and other expenses during this period. The increases in both volume and service intensity are heavily influenced by payer pressures to reclassify certain services previously classified as inpatient services to outpatient services for payment purposes. For example, during this period, BMC has experienced an annual rate of increase of approximately 10% in the volume of outpatient cardiology services and a 20% increase in the volume of outpatient observation services cases, specifically related to the reclassification of services from inpatient to outpatient.

2) Do you see trends in your revenues, from 2006 to 2008 or more recently, that differ materially from these aggregate trends with respect to:
    a. The rate of change in outpatient facility prices and faster revenue growth compared with inpatient revenues;
    b. The growth of revenues for outpatient imaging services;
    c. Price changes versus other sources of growth in revenues, for inpatient and outpatient services.

For commercial payers, from FY2006 to FY2008, BMC has seen a greater increase in outpatient revenues as compared to inpatient revenues; however, our growth for both categories is much less than the trends included in your report. We believe that our revenue growth for inpatient services is primarily price related in line with our cost inflation, while the growth in our outpatient revenues is primarily related to volume growth and service mix changes related to the reclassification of certain services discussed above. BMC has not experienced a significant increase in aggregate outpatient radiology exams.

For the two year period, outpatient commercial revenues have increased at an annual rate of approximately 4.7% compared to an annual rate of 3.1% increase in inpatient revenues. We believe that the 4.7% outpatient growth is composed of a 1.1% volume increase and a 1.7% service mix increase resulting in a 1.9% price change. We estimate that the 3.1% inpatient annual growth rate is composed of a 0.2% volume growth and minimal case-mix (or service intensity) change resulting in a 2.9% price change. In aggregate, BMC outpatient radiology exams increased at an annual rate of approximately 1.5%.

3) What are the one or two most important underlying causes of your experience, as described above? Provide any information you have that will support your assertions. In particular:

    a. What accounts for the growth in inpatient facility prices? What accounts for the growth of hospital outpatient facility price per service? What accounts for the growth in utilization of outpatient hospital facility services? Do you foresee the same factors continuing to drive the growth in total facility revenues in future years?

    b. How does your relative market position or market share affect your cost or revenue trends?

From a pure price position, our increases are in line with or below our cost inflation pressures. With regard to utilization of outpatient services we believe the most significant reason BMC has seen a faster growth in outpatient services is due to the clinical practice trends and payer

insistence on classifying and paying for services as "outpatient", which in the past would have been classified and paid for as inpatient. In aggregate, BMC has seen some of its greatest increases in outpatient services in our observation and cardiac services service lines, both of which relate to procedures or services which in the past would have been classified as inpatient. We do not foresee any change in this trend.

In aggregate, from FY2006 to FY2008, BMC has seen an annual rate of increase of approximately 10% in our outpatient cardiology cases and a 20% annual rate of increase in outpatient observation cases. Both of these areas have experienced clinical practice changes and payer pressures to classify these services as outpatient, as opposed to inpatient, for payment purposes.

In regard to market position or market share, BMC is the only tertiary academic medical center in western Massachusetts and we offer many programs and services that are not available elsewhere in the region. In the provision of these programs and services there is a need to invest in technologies and clinical and academic expertise which may impact our cost structure and revenue requirements as compared to other hospital providers in the region. However, despite the added cost pressures this position in our region puts on us, we believe the payment rates we have negotiated with our commercial payers provide excellent value to our community. This is reflected in the cost and quality metrics as published by the Massachusetts Health Care Quality and Cost Council on their MyHealthCareOptions website. In general, BMC's rates for most measures are at or below the statewide medians for all hospitals.

4) The concentration of teaching hospitals in Boston means that tertiary hospitals effectively serve as the "community hospital" for many patients. If your hospital is located in Boston, what reasonable solutions could your organization develop to provide routine care in less expensive – but appropriate - settings? If your hospital competes for patients with a teaching hospital outpatient facility, how has this impacted your revenues, costs and service mix?

   Not applicable to Baystate Medical Center.

5) Overall, we found an increase in the proportion of services being provided in more expensive settings. Is this trend occurring in your market area? What is driving this trend and what solutions would moderate this trend without impacting quality?

   We are not aware of a shift in services to more expensive settings in our market. Based on our internal data, BMC has not seen significant growth in hospital-based imaging services or outpatient cancer therapies over the time period. Growth in outpatient procedures, particularly in invasive cardiology and interventional radiology is driven primarily by insurance companies' insistence that these patients be classified and paid as outpatients when they were previously classified and paid as inpatients.

6) From 2006-2008, what was your average annual increase in labor costs compared with your average annual increase in patient revenue? What are the major factors driving change in labor costs? What are the major factors driving change in patient revenues?

   From FY2006 to FY2008, BMC experienced an annual rate of increase in total labor costs (salaries and employee benefits) of 7.8% and an annual rate of increase in patient revenues of 5.2%. Our staffing growth as measured in FTE (full-time equivalent) growth increased at an

annual rate of 3.5% and our labor costs per FTE increased at an annual rate of 3.9%. The staffing growth was in line with our aggregate volume and service mix growth which approximated an annual rate of 3.8% as measured by case mix adjusted discharges (outpatient adjusted). The growth in labor costs per FTE can somewhat be attributed to the fact that BMC, not unlike other healthcare providers, has suffered a shortage of nursing and allied health employees. As such, the market for pay within these job categories has rapidly accelerated. In order to retain staff and recruit for open positions, BMC has had to accelerate the pay levels in these job categories to remain competitive in the market, retain existing staff and recruit for open positions. The major factors driving patient revenues were related to volume and service mix. There was a moderate increase in inpatient volumes and a transition of patient volumes from inpatient to outpatient classification, for which, although the provision of care did not materially change, the payments declined due to the lower outpatient payment rates.

7) Are the costs of acquiring medical equipment and technologies increasing, decreasing, or staying the same? Why and how do you think this is the case? What contribution is this having on your overall costs?

The costs of acquiring medical equipment and related technologies are generally increasing. BMC expended approximately $53M for clinical equipment and information systems over the 2006 to 2008 period. Related depreciation on this category of assets grew at an average annual increase of 5.6% over the same period.

These expenditures are absolutely necessary to deliver the highest quality clinical care in a more efficient manner, which our patients have come to expect. Technology related to interventional cardiology and minimally invasive surgery, for example, shortens length of stay in the hospital and shortens patient's return to "normal" activities, including work. Some technology allows for better and quicker diagnosis of diseases allowing treatments to begin sooner resulting in overall improvement in clinical outcomes. BMC has a long standing practice of evaluating new technology on the basis of proven clinical efficacy as well as cost effectiveness.

We believe investments in medical equipment and technology, such as DiVinci Robot and Electronic Medical Records, decrease cost and improve quality over time.

8) What factors do you consider when negotiating payment rates for inpatient care and outpatient services? Please explain each factor (e.g., labor costs) and rank them in the order of impact on negotiated rates.

During negotiation of rates we review underlying costs and total revenue generated by current rates and plan membership. We are constrained by all basic market conditions, including the market power of payers. From our perspective, we attempt to take into consideration the following factors(ranked in order of impact):

- For how many years should we establish future rates?
- What is a reasonable rate of adjustment to cover underlying costs and expected future costs?
- Impact of government payers' payment shortfalls
- Should we consider changing any of the payment methodologies?
- Are we providing any new services that require specific rates?

- Have we adopted new technology that is more expensive on a unit of service basis but will reduce costs overall or improve quality?
- Has the health plan modified any payment policies or claim edits that will affect the level of payment?
- Has the health plan introduced new authorization requirements that will increase denials?
- Has the health plan introduced any new products that will increase the administrative burden or shift costs to the patients?
- Has the health plan membership changed significantly (e.g. increased, decreased, or transitioned from HMO to PPO products)?

In addition, in 2005 BMC implemented a charge rationalization process when implementing annual updates to our individual charge levels. The major components of this process in determining charge levels include: 1- use of actual costs as a baseline, 2- sensitivity to market comparisons, 3- comparisons to payer fee schedules and 4- evaluate and balance the impact on net patient revenues. We believe this provides a rational basis for our annual charge adjustment process. Based upon this process, BMC did not increase its charge levels in 2007 and 2008.

9) Do you generally negotiate contracts with carriers as part of a larger system or as an individual facility? Is there a material difference in how you approach contracts when you are contracting as part of a system vs. as an individual facility?

In order to offer a fully integrated continuum of services to our patients, our preference is to execute contracts as part of a larger system. Health plans recognize the importance of retaining for their members the continuum of services offered by those larger systems, and therefore, they also prefer to execute system contracts. Consequently, it is rare that we negotiate facility contracts on an individual basis. When that has been the case, our approach was not materially different.

10) If applicable, do the services provided in your outpatient facilities in suburban areas differ from those in Boston? If so, how? For those services offered in both locations, do you charge the same or similar rates for all locations? If not, how do the rates – or price paid per person - differ and based on what factors? Are these facilities competing with community physicians or hospitals, or both for the same patients?

Not Applicable to Baystate Medical Center.

11) How has the expansion of outpatient facilities impacted the composition of surgical and medical admissions to your institution? How has the expansion of outpatient facilities impacted the price or cost paid per person of your institution?

We have seen little expansion in outpatient facilities in BMC's service area over the period from 2006 to 2008. Therefore, we cannot attribute any changes in our composition of surgical or medical admissions or the prices paid for services to the expansion of outpatient facilities.

12) How does the variation in prices among different providers in your peer group (e.g., teaching/community hospitals, providers in your geographic area, your key competitors) affect the payment rate increase you seek in negotiations with health plans? Please provide an explanation of how you define your "peer group".

Since providers and health plans are contractually obligated to keep specific payment rates confidential, much of the price information we see is based on medians or ranges. Although many government and health plan websites provide comparative hospital "cost" information, they use "star rating" methodologies to indicate how hospital prices compare overall and for a limited number of defined services. Consequently, pricing variations indicated by this non-specific information do not have a material affect on the payment rates we seek in negotiations. If, however, a health plan indicates during negotiations that we are an outlier with respect to our pricing of specific services, we attempt to be responsive.

As the only tertiary academic medical center surronded by local community hospitals in our service area, we are sensitive to the need to keep our costs as low as possible in order to negotiate rates that health plans believe are reasonable and that enable us to continue to provide such a broad range of services to the patients in our market. We know that plans appreciate our ability to do this since generally it would cost them significantly more if their members had to travel out of our market for those services.

While we share the same geographic market with local community hospitals, two of which we are directly affiliated with, we do not generally consider them to be in our "peer group". Rather, we consider our "peer group" to include those tertiary academic medical centers with which we compare and benchmark performance metrics such as quality, cost and efficiency.

13) What specific actions has your organization taken already to address these trends in the short term or long term? What current factors limit the ability of your organization to execute these strategies effectively?

BMC has always focused on cost control. Many of the cost control initiatives we have implemented are detailed below. Our ability to effectively execute these and other cost control strategies is limited by our ability to fund operating and capital investments.

Some of our specific cost control initiatives are:

- Reduction in unit costs (Management of cost per unit of service delivered).
  - Consolidation of administrative and support functions where appropriate.
  - Supply chain initiatives (vendor pricing, supply standardization, etc.).
  - Pharmacy cost reductions (including utilization of the 340B drug pricing program).
  - Best practice functional benchmarking and productivity reviews.
  - Maximizing staffing efficiency by matching patient flow with nurse staffing requirements, etc.
  - Achievement of Magnet Hospital status for excellence in nursing for the second time. Only 2% of hospitals have received consecutive designations like BMC. Magnet status recognizes excellence in a variety of areas including nursing management, philosophy and practices, and adherence to standards for improving quality of patient care, which helps to reduce costs.

- Utilization management (Management of amount of services delivered per episode of care):
  - Through a physician directed approach, BMC has reduced unnecessary utilization while applying evidence based medicine to achieve high quality at low costs.
  - BMC has implemented a program to utilize hospitalists to better manage inpatient care in a cost-effective manner

- BMC has employed physician directed performance improvement teams to review evidence, utilization data and create guidelines and decision support tools to drive quality and cost reduction.
- Each year BMC benchmarks costs against 600 hospitals and sets specific goals to reduce overuse within the inpatient setting.
- BMC has been a leader in the use of Electronic Medical Record's (EMR) for many years which has resulted in increased reliability, quality and safety, and reduced unnecessary diagnostic testing. This has resulted in millions of dollars of reduced costs.
- Related to EMR, we have achieved over 95% physician utilization of electronic order entry, which is among the leaders in the United States.
- Most recently BMC has employed LEAN thinking to reduce process waste through LEAN techniques.
- BMC has been named to the Leapfrog Top 45 Best Hospitals in 2009 which includes both quality and efficiency measures, and has regularly been recognized with the Beacon Awards for Critical Care Excellence.

- Wellness programs, disease management and appropriate care setting (Development of programs for prevention and to properly match care needs to the proper setting and delivery of that care). BMC is committed to improving health care delivery and providing programs and services that address the identified health and wellness needs of its constituencies and communities served:
    - In the spring of 1996, BMC and other key stakeholders established Partners for a Healthier Community, a nonprofit organization committed to building a measurably healthier Springfield. BMC has underwritten the mission of the organization, investing $2.7 million. In turn the organization has leveraged this investment earning over $5.7 million from other sources for a total contribution of $8.4 million in community health improvements to address unmet health needs in vulnerable populations and ethnically and culturally diverse communities.
    - In 2007, the Massachusetts Department of Public Health approved BMC's Determination of Need (DoN) application for its Master Facility Plan. In accordance with DoN Factor 9 requirements, BMC developed a plan to provide an array of new or additional community based services. BMC committed $9.6 million over a seven-year period or $1.3 million per year for the provision of health education and preventive health care services to improve population-based health in the project's service area.
    - BMC's community outreach services include three full service community health centers and Western Massachusetts' largest Ob/Gyn clinic.
    - BMC has taken proactive steps to improve the health of our employees through our Baystate Healthy wellness programs. Baystate Healthy includes health risk assessments, screenings and consultations, fitness, stress management, smoking cessation, nutrition/weight management, better sleep and other programs. Because we strongly encourage wellness, our health plans provide free well care visits.

14) What types of systemic changes would be most helpful in reducing cost trends without sacrificing quality and consumer access? What other systemic or policy changes do you think would encourage or help health care providers to operate more efficiently? What changes would you suggest to encourage treatment of routine care at less expensive, but appropriate settings?

Outlined below are various systemic changes that would be helpful in reducing cost trends without sacrificing quality and access. They include treatment of routine care at less expensive settings, such as a primary care practice.

- Administrative Simplification:
  - Standardize and simplify authorization and referral rules.
  - Uniform ID cards that clearly identify plans and their products.
  - Standardize eligibility response systems.
  - Health plans should have pre-established limited time period to retroactively review prior approved claims.
  - Denial remark codes related to national coding standards should be uniformly used by all health plans.
  - Health plans should give appropriate prior notification of any changes in their policies and procedures.
  - Health plans should fully disclose their claims processing logic.
  - Standardized reporting requirements to improve productivity and reduce cost.
  - A single entity responsible for credentialing providers one time on behalf of all plans.
  - A single entity responsible for determining the medical efficiency of clinical interventions for all plans.
- Reduction in Clinical Variation and Utilization:
  - BMC has undertaken many initiatives to reduce clinical practice variations thus improving quality and reducing costs. This concept should be fully expanded to care provided outside of the hospital through the development of continuum of care practice guidelines.
- Increase Access to Primary Care:
  - Access to primary care will reduce unnecessary costly visits to the hospital emergency room for primary care services and reduce the progression to more acute stages of an illness through early detection.
- Investment in Consumer Education & Wellness:
  - Public health driven initiatives to improve population-based wellness and disease prevention and disease management programs.
- Payment and Care Delivery Reform:
  - Creation of "medical homes" and "accountable care organizations" that manage the full continuum of care and are accountable for the cost and quality of care for a defined population.
  - Disease management initiatives.
  - Implementation of EMR to drive reliability for quality and reduce unnecessary diagnostic testing
  - Reduce government mandates
  - Better control of pharmaceutical cost through use of generic drugs, etc.
  - Tort reform related to malpractice awards
  - Implement hospital industry's alternative proposal in lieu of mandatory nurse staffing ratios.

15) Could enhanced competition or government intervention or a combination of both mitigate the cost trends found in the Divisions report? Please describe the nature of the changes you would recommend. In addition, please address the following:

a. What would be the impact on your organization of making data public regarding quality and the reimbursement rates paid by each carrier to each hospital or system in a manner that identifies all relevant organizations? What is the advantage or disadvantage to your organization of the current confidential system?

We recommend that government payers increase payment levels to cover costs of care so that the burden of the shortfall is not shifted to the commercial payers. In order to offset this payment shortfall we must negotiate higher payment rates from our non-governmental payers. Therefore, if the government payers would increase their rates to cover the costs and provide a margin for our ability to invest in new capital technologies this would likely result in lower price increases to commercial payers.

Specific ideas to increase government payments include:

1. Increase Medicare payment rates for certain outpatient services where payments currently do not cover costs
2. Restore Medicaid reimbursement for graduate medical education.
3. Begin Medicaid reimbursement for allied medical professional education.
4. Ensure adequate and appropriate payment rates from MassHealth (e.g., Statewide Payment Amounts per Discharge do not correspond to current case mix) and Health Safety Net for services delivered by hospitals.

Other ideas for governmental intervention include:

1. Develop and implement a statewide strategy to recruit primary care physicians and expand primary care capacity in the state.
2. Address primary care access problems by encouraging alternative care sites and after-hours options to hospital emergency departments.

With regard to making data public, BMC is a supporter of meaningful consumer transparency. We fully embrace quality improvement efforts and believe there is a place for disclosure to the consumer of quality information so long as it is clinically valid and understandable to the consumer. However, we question both the usefulness to the consumer and the fairness to the individual hospital of the disclosure to the public of reimbursement rates paid by each carrier to a hospital. Consumers do not have a direct "out-of-pocket" expenditure equal to the amount paid to the hospital. Therefore, we question how this disclosure will impact consumer behavior. For hospitals, the comparison of amounts negotiated with non-governmental payers between hospitals may not necessarily be directly related to any true 'cost' differences. As we have indicated earlier, governmental payments are not covering the costs of the services provided to their patients and therefore, in order to be financially viable, hospitals must make up for this through their negotiations with commercial payers. Hospitals are in different positions related to this issue and therefore without a resolution, which would level the playing field, we believe it is confusing to disclose reimbursement information to the public.

16) Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

Additional key drivers of escalating health care costs, that should be examined in the future years, include end of life care, an aging population, changing demographics, higher survival rates from chronic disease and the explosion of technology and new drugs. In the future the creation of "Medical Homes" and "Accountable Care Organizations" may be beneficial in addressing the

cost and quality of care for a defined population. BMC is currently researching these healthcare delivery structures.

As indicated above, government (Medicare and Medicaid) payments for services to hospitals, which generally do not cover costs, need to be addressed. Currently, hospitals must try to make up this "shortfall" by negotiating higher rates from private insurers.

17) Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

The healthcare delivery system relies on many complex associations and relationships. BMC is not only the region's only tertiary academic medical center, it is a critical part of a regional integrated healthcare delivery system, which includes other less financially viable providers, including two community hospitals and primary care and specialty physician practices. We believe this integrated approach, as a whole, provides for higher quality care and better efficiencies for delivery of healthcare services in our region then could be provided by separate stand-alone providers. In the long run, costs will be much better controlled through such systems.

Attorney General's Office Questions
and Baystate Medical Center's Testimony

1) Please explain and submit a summary table showing your internal costs and cost trends from 2004 to 2008 broken out to show categories of aggregate direct costs (e.g., labor costs for all cost centers) and categories of indirect costs including, but not limited to, debt service, depreciation, advertising, bad debt, stop-loss insurance, malpractice insurance, health safety net, development/fundraising, administration, research, academic costs. Please explain and submit supporting documents to show the methodologies you use to allocate the categories of indirect costs to cost centers (operating units).

Labor cost, which includes salaries and fringe benefits, has increased annually on average by 7.9% between FY2004 and FY2008. Our FTEs have increased annually on average by 3.8% during this period. Most of this increase is in nursing, technicians and specialists who have higher than average wages. Annual wage increases during this period approximated 4%. BMC, not unlike other healthcare providers, has suffered a shortage of nursing and allied health employees. The market for pay within these job categories has rapidly accelerated. In order to retain staff and recruit for open positions, BMC has had to accelerate the pay levels in these job categories to remain competitive in the market, retain existing staff, and recruit for open positions. Our overall patient volume and service mix, as measured in case mix adjusted discharges (outpatient adjusted), has increased at an annual rate of 3.7% over this period which approximates the FTE growth and is more than half of the growth in total expenses of 6.7%.

Non-labor cost has increased annually on average by 5.5% over this period. The increase in volume and case mix has a direct impact on patient supplies, drugs and other expenses. Our non-labor cost has increased based on inflation.

Baystate Medical Center (in millions)	**FY2004**	**FY2005**	**FY2006**	**FY2007**	**FY2008**	**Average Annual Change**
Labor Costs	$284.5	$301.3	$333.2	$360.3	$385.7	7.9%
Bad Debts	$20.6	$22.7	$19.6	$15.0	$11.9	(12.8%)
Depreciation	$34.0	$43.2	$38.6	$38.2	$40.6	4.5%
Interest	$11.1	$11.8	$10.5	$10.4	$9.2	(4.6%)
Malpractice	$7.5	$7.4	$6.9	$7.3	$6.9	(2.0%)
Administration and Information Technology	$62.5	$75.3	$76.5	$85.0	$84.4	7.8%
Research	$3.5	$3.9	$4.0	$5.5	$6.9	18.5%
Academic	$16.2	$17.7	$19.2	$14.5	$19.3	4.5%
Other Supplies and Expense	$164.7	$179.0	$203.7	$213.1	$217.9	7.3%
Total Other Cost	$320.1	$361.0	$379.0	$389.0	$397.1	5.5%
Total Expense	$604.6	$662.3	$712.2	$749.3	$782.8	6.7%

Indirect costs are allocated to our operating units using a step-down allocation methodology similar to the DHCFP – 403 Cost Report. Indirect Costs include allocations of overhead costs related to facility depreciation & operations, finance, Health Information Management, Access Services, food services, materials management/distribution, case management & performance improvement, Information services and senior management and other administrative costs. Indirect costs are assigned to revenue generating cost centers using a step-down allocation methodology.

See table below which lists our overhead step-down statistics.

Baystate Medical Center	
Cost Accounting System	**Overhead Statistics**
Benefits	Gross Salaries
Depreciation, Utilities, Enviromental Services, Engineering	Square Feet
Billing	Gross Charges
Payroll, Security, Mail Service, Cafeteria	FTEs
Medical Records	Department Statistic
Distribution Services	Department Statistic
General Overhead	Direct Expense

Assignment of department costs, including allocated overhead, to individual service items within a revenue producing cost center, using Relative Value Unit (RVU) Methodology.

Each service item is assigned RVUs for:

- Salaries, Wages & Benefits – typically based on time. Some areas use engineered standards used in Flex Budget or alternative methods determined independently by cost center management and the DS staff.
- Other direct costs typically spread equally among all service items in cost center or other statistical basis specific to a cost center (Send out tests in lab are based on cost of send out test)
- Supplies and Drugs based on actual acquisition cost for unit of service
- Overhead is typically allocated based on the accumulated RVUs for the service item.

2) Please explain and submit supporting documents that show any steps you have taken to reduce or control the growth of your internal direct or indirect costs in the last 5 years.

See our response to Division of Health Care Finance & Policy Question #13.

3) Please explain and submit a summary table showing your annual operating margins (positive or negative) from 2004 to 2008 for your entire commercial, government, and all other business (and please identify the carriers or programs included in each of these three aggregate margins). Please explain and submit supporting documents to show the mechanics of how you calculate your margin from your accounting system and identify whether you exclude any direct costs or indirect costs, or include any grants, donations, or non-patient revenue, in calculating your margins.

BMC's cost accounting system calculates the annual operating margin by patient and then aggregates all patients into their primary payor to determine a payor's operating margin. We calculate the expected reimbursement for each patient based on the services received and the associate primary payor's contract payment terms. We include both direct and indirect cost in our margin calculations. We include other operating revenue in our margin calculations. We include non-patient revenue.

Baystate Medical Center Operating Margin (in millions)					
	FY 2004	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**
Governmental	unavailable	($8.5)	($9.7)	($10.7)	($4.0)
Commercial	unavailable	$43.3	$54.8	$53.2	$45.3
Other Business	unavailable	$1.9	($1.8)	$5.4	$7.2
Total	$26.0	$36.7	$43.3	$47.9	$48.5

Governmental Includes:

Medicare
Massachusetts Medicaid

Commercial Includes:

Aetna Insurance
Blue Cross of Massachusetts
Boston Medical Center Health Net
CHAMPUS
CIGNA Health Plan
CTCare of Massachusetts
GIC Indemnity Plan
Health New England
Mass Behavioral Health Partnership
Neighborhood Health Plan
Network Health
Tufts Associated Health Plan
United Health Care
Various Automobile Insurance Plans
Various Other Commercial Insurance Plans
Various Workers Compensation Plans

Other Business includes miscellaneous transactions relating to prior years.

4) Please explain and submit supporting documents that show how your DHCFP-403 Cost Report submission differs from your own internal cost information including any difference in direct costs, indirect costs, or non-patient revenue.

BMC total expenses reported on its DHCFP-403 Cost Report differ from its Financial Statements based on DHCFP treatment of certain costs. BMC's total expense reported on its 2008 DHCFP – 403 Cost Report is lower than its Audited Financial Statements by $10.3 million.

1	Health Safety Net Assessment	$5.5
2	Related Party Adjustment	($14.0)
3	Remove Bad Debt recoveries from cost	$1.0
4	Exclude cost determined to be non-allowable	($3.0)
	Other	$.2
	Total	($10.3)

1. DHCFP – 403 Cost Report treats our $5.5 million Health Safety Net assessment as an expense where our Financial Statements treat this as an offset to our draw for reimbursement for Health Safety net eligible services.

2. DHCFP – 403 Cost Report includes a $14.0 million reduction in BMC related party Financial Statement expenses based on Medicare cost finding methodologies.

3. DHCFP – 403 Cost Report treats our $1.6 million in Bad Debt recoveries as Other Operating Revenue where our Financial Statements treats this as a reduction to Bad Debt expense.

4. DHCFP – 403 Cost Report excludes $3.0 million of cost determined to be non-allowable.

5) Please explain and submit a summary table showing your annual capital ratio, debt service coverage ratio, and cash on hand for fiscal years 2004 to 2008 and include any target ratios and cash position you have set to obtain bond or bank financing. Please explain how your capital expenditures (property and equipment), restricted capital donations, and changes in cash position (endowment) have increased or decreased your internal costs and margin calculations.

	Target	FY2004	FY2005	FY2006	FY2007	FY2008
Annual Capital Ratio	None	1.11	1.00	1.00	1.05	1.63
Debt Service Coverage Ratio	1.10[A]	4.61	5.55	4.79	5.92	5.39
Days cash on hand	174.6[B]	137.6	134.1	166.5	193.3	152.9
[A] Required by existing Bond Covenants						
[B] Internal Target (based on S&P A+ rated hospitals)						

The increase in the annual capital ratio in 2008 is due to a planned increase in capital spending related to the new BMC Hospital of the Future which is currently under construction but has not been placed in service. This transaction had no impact on the BMC margin calculations.

The Debt Service Coverage Ratio has fluctuated over the time period primarily due to the fluctuations in operating margin. Debt service has remained stable over the time period. Interest expense has declined slightly having positive effect on operating margin.

BMC has made an effort over the years to increase cash balances. The significant decline between 2007 and 2008 of approximately 40.4 days is due primarily to declines in the market

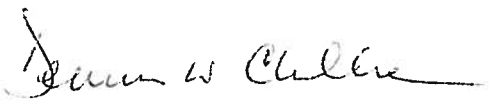
value of the investments. The decline in days cash on hand attributable to the increase in capital expenditures is approximately 12 days, which was a planned increase in capital funding.

6) Please explain and submit supporting documents that show your internal costs, including any stop-loss coverage, for any risk you currently bear related to your contracts with commercial insurers. Please include any analysis you have conducted on how much your costs and risk-capital needs would change based on increases or decreases in risk you bear in relation to your business with commercial insurers.

   Although all of BMC's contracts have some degree of inherent financial risk that the payment amounts it receives may not be adequate to cover the cost of care and government shortfalls, BMC currently has very few risk-based (e.g. capitated) contracts with commercial insurers (less than 1% of commercial revenue) and thus does not track internal costs for such risk.

I am legally authorized and empowered to represent Baystate Medical Center for the purposes of this testimony. I hereby certify under the pains and penalties of perjury that, under my direction, BMC has made a diligent effort to respond to the foregoing questions, and that, to the best of my knowledge, information, and reasonable belief, the foregoing answers are true and correct.

Sincerely,



Dennis W. Chalke
VP, Finance and CFO Healthcare Operations